STATE OF SOUTH CAROLINA
DEPARTMENT OF CONSUMER AFFAIRS

PRESCRIPTION DRUG DISCOUNT CARD REGISTRATION

S.C. Code Ann. § 37-17-10 et seq.

Mailing Address
P.O. Box 5757
Columbia, SC 29250-5246

www.scconsumer.gov
(803) 734-4200

Street Address
3600 Forest Drive
Columbia, SC 29204-4006

Name of Business: _____

Home Office/ Business Address: _____

City: _____ State: _____ Zip: _____

Telephone No: _____ Fax No.: _____

E-Mail Address: _____ Web Site: _____

Contact Person: _____

Address: _____

Telephone No. _____ Fax No.: _____

E-Mail Address: _____

In addition to this registration form, you must provide:

1. A copy of the card or other purchasing mechanism or device provided to consumers, plus a copy of all advertisements, which must expressly state in bold and prominent type, prominently placed, that the discounts are not insurance.

2. A copy of the contract(s) that the business has with each participating pharmacy or pharmacy chain; or attach a certification that states the discounts are specifically authorized and the person has a separate contract with each pharmacy or pharmacy chain listed in conjunction with the card or other purchasing mechanism or device.

3. A list of all participating pharmacies in South Carolina.

4. A copy of the business' Articles of Incorporation, a certified copy of Good Standing Certificate, and a copy of a foreign corporation's Certificate of Authority to Transact Business in the State of South Carolina, as applicable.

5. The name of the agent for service of process and documentation that the agent has been registered with the South Carolina Secretary of State. This item requires a completion of the "Office of Secretary of State Designation of Registered Agent for Discount Drug Card Sellers" form, which is available at www.scsos.com/forms/miscellaneous/drugcard.pdf. **The Department requires an original copy of the form which has been certified by the Secretary of State.** Therefore, you should file at least two original copies with the Secretary of State.

Affidavit of Applicant

I swear or affirm and certify that I have completed and/or reviewed all information on this form and submitted with this Application, and to the best of my knowledge and belief, all information contained herein is true, correct and complete; and that there are no material omissions of fact which would have a bearing upon the South Carolina Department of Consumer Affairs' decision to grant the requested license. I further certify that I understand that giving false information constitutes cause for denial or revocation of the application and subjects me to criminal prosecution for perjury. I acknowledge that I have a duty and agree to update and correct this information as it changes.

_____

Signature

_____

Date

_____

Type or Print your name and Title

SWORN TO AND SUBSCRIBED before me

this _____ day of _____, 20_____

_____ (SEAL)

Notary Public For _____

My Commission Expires:

_____

The completed Application should be submitted to:

South Carolina Department of Consumer Affairs
Attn: Prescription Drug Discount Card
P.O. Box 5757
Columbia, SC 29250-5757

Do not fax this form. An original, signed and notarized form is required.

The South Carolina Freedom of Information Act may require the Department of Consumer Affairs to release this form as a public record; however personal identifying information will be released only if required by law.